SECTION 8

Post-acute care

Skilled nursing facilities
Home health services
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1. Number of post-acute care providers increased or remained stable in 2013

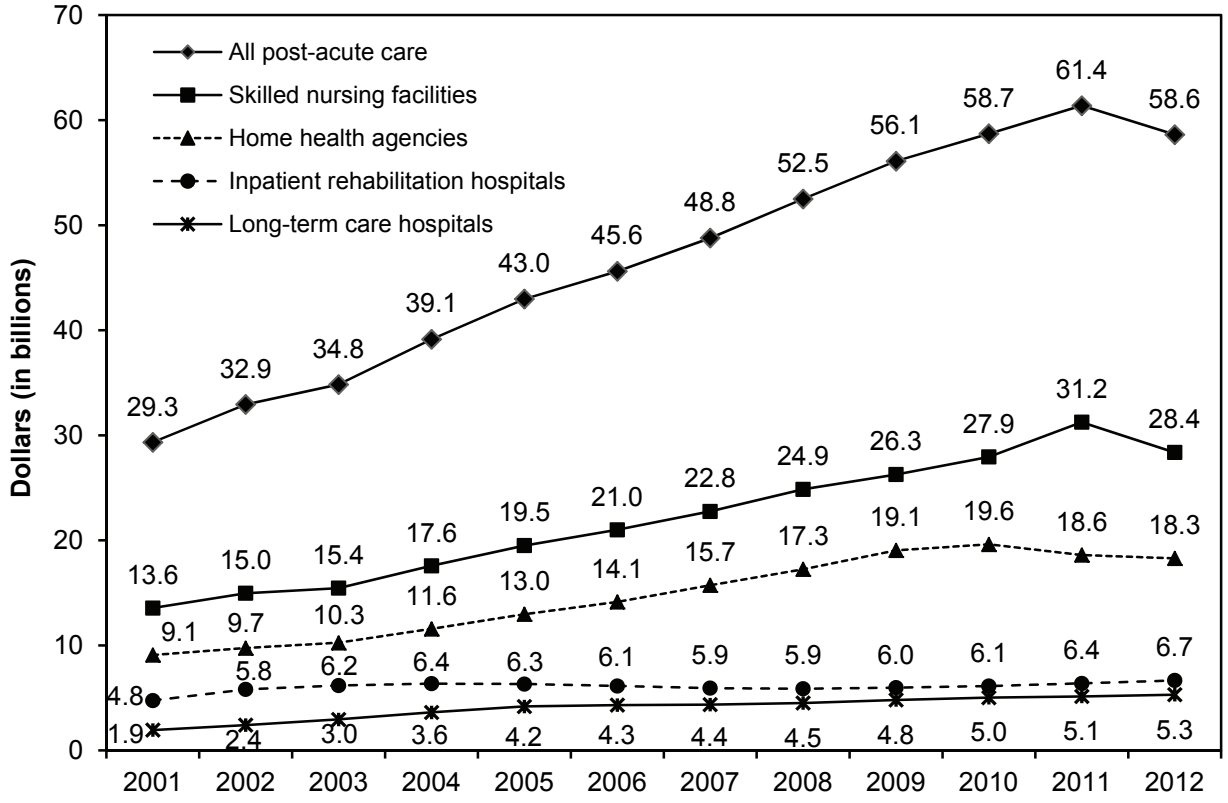
	2005	2006	2007	2008	2009	2010	2011	2012	2013	Average annual percent change 2005–2012	Percent change 2012–2013
Home health agencies	8,314	8,955	9,404	10,040	10,961	11,654	12,026	12,225	12,613	5.4%	3.2
Inpatient rehabilitation facilities	1,235	1,225	1,202	1,202	1,196	1,179	1,165	1,166	1,161	–0.8	–0.4
Long-term care hospitals	388	392	396	402	427	438	437	437	432	1.4	–1.1
Skilled nursing facilities	15,026	15,017	15,047	15,024	15,062	15,076	15,120	15,139	15,163	0.1	0.2

Note: The skilled nursing facility count does not include swing beds.

Source: MedPAC analysis of data from the Provider of Services files from CMS.

- The number of home health agencies has increased substantially since 2005. The number of agencies increased by 388 in 2013. The growth in new agencies is concentrated in a few areas of the country.
- In spite of a moratorium on new long-term care hospitals (LTCHs) beginning in October 2007, the number of these facilities continued to grow through 2010. The number of LTCHs dropped from 437 in 2012 to 432 in 2013.
- The total number of skilled nursing facilities has increased slightly since 2005, and the mix of facilities shifted from hospital-based to freestanding facilities. In 2013, hospital-based facilities made up 5 percent of all facilities, down from 8 percent in 2005.

Chart 8-2. Home health care and skilled nursing facilities have fueled growth in Medicare's post-acute care expenditures



Note: These numbers are program spending only and do not include beneficiary copayments.

Source: **AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2014. THIS CHART REFLECTS DATA FROM THE 2013 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2014 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.**

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- Increases in fee-for-service (FFS) spending on post-acute care have slowed in part because of expanded enrollment in managed care under Medicare Advantage; Medicare Advantage spending is not included in this chart.

- FFS spending on inpatient rehabilitation hospitals declined from 2005 through 2008, reflecting policies intended to ensure that patients who do not need this intensity of services are treated in less-intensive settings. However, spending on inpatient rehabilitation hospitals has increased since 2009.

- FFS spending on skilled nursing facilities increased sharply in 2011, reflecting CMS's adjustment for the implementation of the new case-mix groups (resource utilization groups, version IV) beginning October 2010. Once CMS established that the adjustment it made was too large, it lowered the adjustment, and spending dropped in 2012.

Chart 8-3. A growing share of fee-for-service Medicare stays and payments go to freestanding SNFs and for-profit SNFs

	Facilities		Medicare-covered stays		Medicare payments (billions)	
Type of SNF	2006	2012	2006	2012	2006	2012
Totals	15,178	14,938	2,454,263	2,396,548	$19.5	$26.2
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	70	79	82	81	84
Rural	33	30	21	18	19	16
For profit	68	70	67	71	73	75
Nonprofit	26	25	29	25	24	21
Government	5	5	4	3	3	3

Note: SNF (skilled nursing facility). Totals may not sum to 100 due to rounding and missing values.

Source: MedPAC analysis of the Provider of Services, Medicare Provider Analysis and Review files 2006 and 2012.

- The mix of where beneficiaries receive SNF services has shifted towards freestanding, urban, and for-profit facilities.
- In 2012, freestanding facilities accounted for 94 percent of stays and an even larger share of Medicare's payments.
- In 2012, urban facilities accounted for 70 percent of facilities, 82 percent of stays, and 84 percent of Medicare payments.
- In 2012, for-profit facilities accounted for 70 percent of facilities, but higher shares of stays and Medicare payments (71 percent and 75 percent, respectively).

Chart 8-4. SNF service use declined between 2011 and 2012

Volume measure	2006	2008	2010	2011	2012	Percent change 2011–2012
Covered admissions per 1,000 FFS beneficiaries	72	73	71.5	71.2	68	–4.5%
Covered days (in thousands)	1,892	1,977	1,938	1,935	1,861	–3.8
Covered days per admission	26.3	27.0	27.1	27.2	27.4	0.7

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Information Products and Data Analytics 2012.

- In 2012, 4.5 percent of beneficiaries used SNF services, down slightly from 2011 (not shown).
- Admissions per 1,000 FFS beneficiaries decreased 4.5 percent, paralleling the declines in inpatient hospital use. An acute hospital stay of three or more days is a prerequisite for Medicare coverage of SNF care.
- Covered days declined at a slower pace (3.8 percent), resulting in a slight increase in covered days per admission.

Chart 8-5. Freestanding SNF Medicare margins remain high despite reductions in payments

	2002	2004	2006	2008	2010	2011	2012
All	17.5%	13.8%	12.8%	16.7%	19.4%	21.2%	13.8%
Rural	20.3	16.1	13.5	17.9	19.4	20.4	12.9
Urban	16.9	13.3	12.7	16.4	19.4	21.4	14.0
Nonprofit	9.1	3.7	3.1	7.1	10.7	13.6	5.4
For profit	19.5	16.2	15.2	19.0	21.6	23.2	16.1

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports 2006–2012.

- In 2011, the average Medicare margin for freestanding SNFs was 21.2 percent, reflecting the large increase in payments with the implementation of the new case-mix groups and an incorrect adjustment factor. In 2012, CMS corrected the adjustment, and margins were lower. Margins have declined since 2010 because current law has required market basket increases to be offset by a productivity adjustment since 2011.
- Though lower than in recent years, the 2012 Medicare margin is the 13th year of Medicare margins above 10 percent.
- In 2012, on average, urban facilities had slightly higher Medicare margins than rural facilities, and for-profit SNFs had higher Medicare margins than nonprofit SNFs. Rural facilities have higher base rates than urban facilities.
- In 2012, total margins (the margin across all payers and all lines of business) for freestanding facilities remained positive (1.8 percent, not shown).

Chart 8-6. Cost and payment differences explain variation in Medicare margins for freestanding SNFs in 2012

Characteristic	Highest margin quartile (n = 3,136)	Lowest margin quartile (n = 3,137)	Ratio of highest quartile to lowest quartile
Cost measures			
Standardized cost per day	$247	$355	0.7
Standardized cost per discharge	$11,389	$13,268	0.9
Average daily census (patients)	89	70	1.3
Average length of stay (days)	47	36	1.3
Revenue measures			
Medicare payment per day	$467	$421	1.1
Medicare payment per discharge	$22,562	$15,633	1.4
Share of days in intensive therapy	79%	70%	1.1
Share of medically complex days	4	6	0.7
Medicare share of facility revenue	26	16	1.6
Patient characteristics			
Case-mix index	1.37	1.28	1.1
Dual-eligible share of beneficiaries	40%	26%	1.5
Percent minority beneficiaries	12	4	3.0
Percent very old beneficiaries	30	36	0.8
Medicaid share of days	65	59	1.1
Facility mix			
Percent for-profit	89%	59%	N/A
Percent urban	77	68	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Values shown are medians for the quartile. Highest margin quartile SNFs were in the top 25 percent of the distribution of Medicare margins. Lowest margin quartile SNFs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs per day are Medicare costs adjusted for differences in area wages and the case mix (using the nursing component's relative weights) of Medicare beneficiaries. Intensive therapy days are days classified into ultra-high and very-high rehabilitation case-mix groups.

Source: MedPAC analysis of freestanding 2012 SNF cost reports.

- Medicare margins varied widely across freestanding SNFs. One-quarter of SNFs had Medicare margins at or below 4.8 percent, and one-quarter of facilities had Medicare margins at or above 23 percent (data not shown).
- High-margin SNFs had lower costs per day (30 percent lower costs than low-margin SNFs), after adjusting for wage and case-mix differences, and higher revenues per day (1.1 times the revenues per day of low-margin SNFs).
- Facilities with the highest Medicare margins had higher case-mix indexes, higher shares of beneficiaries who were dually eligible for Medicare and Medicaid, and higher shares of minority beneficiaries.

Chart 8-7. Financial performance of relatively efficient SNFs reflects a combination of lower cost per day and higher payments per day

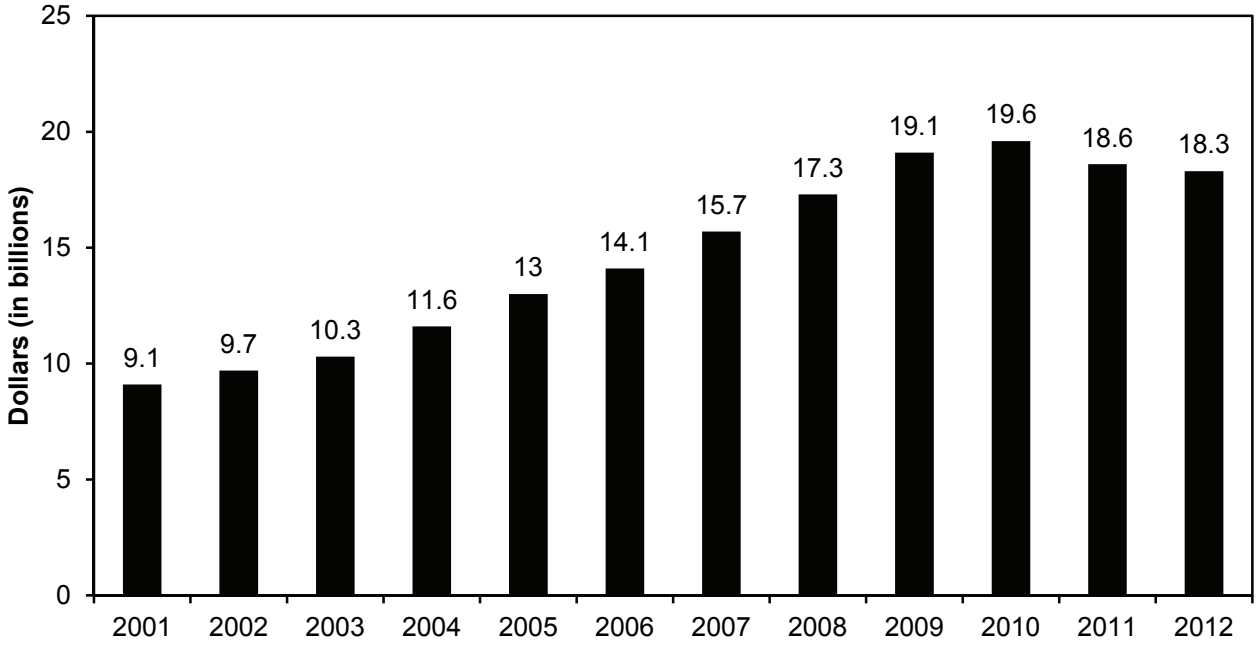
	Relatively efficient SNFs (11%)	Other SNFs (89%)
Performance in 2011		
Relative* community discharge rate	1.18	0.97
Relative* rehospitalization rate	0.88	1.02
Relative* cost per day	0.96	1.01
Medicare margin	25.0%	22.7%
Performance in 2012		
Relative*community discharge rate	1.16	0.97
Relative* rehospitalization rate	0.89	1.02
Cost per day	$280	$292
Medicare margin	17.3%	15.0%
Facility case-mix index	1.36	1.35
Medicare payment per day	$463	$453
Medicare average length of stay	33 days	39 days
Share intensive therapy days	76%	77%
Total margin	3.5	2.3
Medicaid share of facility days	58%	62%
Trends in cost and revenue growth 2005–2010		
Share of facilities with low growth in cost per day	17%	83%
Share of facilities with high growth in revenue per day	12%	88%

Note: SNF (skilled nursing facility). There were 7,814 freestanding facilities included in the analysis. Efficient SNFs were defined by their cost per day (2008–2010) and two quality measures (community discharge and rehospitalization rates) for 2008 through September 2010. Efficient SNFs were those in the lowest third of the distribution of one measure and not in the bottom third on any measure in each of three years. Costs per day were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted community discharge and rehospitalization for patients with potentially avoidable conditions within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. Intensive therapy days include days classified into the ultra-high and very-high case-mix groups.
* Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2008–2012 and Medicare cost report data for 2005–2012.

- Relatively efficient SNFs were defined as consistently providing relatively low-cost and high-quality care compared with other SNFs.
- Compared with national averages, relatively efficient SNFs furnished considerably higher quality (higher discharge to community rates and lower readmission rates) and had costs per day that were 4 percent lower.

Chart 8-8. Spending on home health care, 2001–2012



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- In October 2000, the prospective payment system (PPS) replaced the previous Medicare payment system. At the same time, eligibility for the benefit broadened slightly.
- Home health care has risen rapidly under the PPS. Spending rose by about 10 percent a year between 2001 and 2009, but growth slowed beginning in 2010 and has remained relatively flat since 2011.
- Spending dropped by an estimated $400 million in 2012. This decline was attributable to two factors: The base rate for home health care declined, and the number of episodes declined slightly. Despite these declines, spending in 2012 was more than double the spending for 2001.

Chart 8-9. Trends in the provision of home health care

				Average annual percent change		Cumulative change
	2002	2011	2012	2002–2011	2011–2012	2002–2012
Number of users (in millions)	2.5	3.4	3.4	3.5%	–0.2%	36.6%
Percent of beneficiaries who used home health care	7.2%	9.6%	9.0%	3.2	–1.5	31.0
Episodes (in millions)	4.1	6.8	6.7	5.9	–1.5	64.5
Episodes per home health patient	1.6	2.0	2.0	2.2	–1.3	20.4
Visits per home health episode	18.4	17.2	16.9	–0.7	–1.8	–8.2
Visits per home health patient	31	34	33	1.0	–3.4	7.4
Average payment per episode	$2,335	$2,691	$2,677	1.6	–0.5	14.6

Source: MedPAC analysis of the home health Standard Analytic File.

- Under the prospective payment system, in effect since 2000, the number of users and the number of episodes have risen significantly. In 2012, 3.4 million beneficiaries used the home health benefit.

- The number of home health episodes increased rapidly from 2002 to 2012, though growth has slowed in recent years. The number of beneficiaries using home health care has also increased since 2002, but at a lower rate than the growth in episodes.

- The number of visits per episode decreased from 2002 to 2012. However, this decline was offset by an increase in the average number of episodes per patient, which increased from 1.6 in 2002 to 2.0 in 2012 (not shown). Beneficiaries received fewer visits in an episode but had more 60-day episodes of care. As a result, the average number of visits increased from 31 visits per home health user in 2002 to 33 visits per home health user in 2011.

Chart 8-10. Home health episodes not preceded by a hospitalization account for the majority of services in 2011

	Number of episodes (in millions)		Cumulative growth	Share of episodes	
	2001	2011		2001	2011
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.3	67%	20%	19%
Subsequent	1.3	3.2	148	32	46
Subtotal	2.1	4.5	117	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	17	40	27
Subsequent	0.3	0.5	66	8	7
Subtotal	1.9	2.3	25	47	34
Total	3.9	6.8	73	100%	100%

Note: PAC (post-acute care). "First" indicates no home health episode in the 60 days preceding the episode. "Subsequent" indicates the episode started within 60 days of the end of a preceding episode. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the start of the episode. "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred less than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. Numbers may not sum due to rounding.

Source: CMS Datalink file 2012.

- The rise in the average number of episodes per beneficiary coincides with a relative shift away from using home health care as a PAC service.

- During the 2001 through 2011 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 117 percent, compared with a 25 percent increase in episodes that were preceded by a hospitalization or PAC stay. During that period, the share of all episodes preceded by a hospitalization or PAC stay rose from about 53 percent to 66 percent.

- Beneficiaries for whom the majority of home health episodes in 2010 were preceded by a hospitalization or other post-acute stay had different characteristics than community-admitted beneficiaries. Community-admitted home health users were more likely to be dually eligible for Medicare and Medicaid, had more home health episodes, and had more episodes with a high share of home health aide services compared with post-acute users of home health (not shown in table). Community-admitted users generally had fewer chronic conditions, tended to be older, and had a higher rate of dementia and Alzheimer's disease.

Chart 8-11. Medicare margins for freestanding home health agencies

	2011	2012	Percent of agencies 2012
All	15.0%	14.4%	100%
Geography			
Mostly urban	14.8	14.8	83
Mostly rural	15.5	12.8	17
Type of control			
For profit	15.8	15.2	88
Nonprofit	12.0	12.0	12
Volume quintile			
First	6.8	6.8	20
Second	8.3	8.0	20
Third	10.1	10.2	20
Fourth	13.5	13.2	20
Fifth	17.4	16.7	20

Note: Agencies are characterized as urban or rural based on the residence of the majority of their patients. Agencies with outlier payments that exceeded 10 percent of Medicare revenues are excluded from the reported statistics.

Source: MedPAC analysis of 2011–2012 Cost Report files.

- In 2012, freestanding home health agencies (HHAs) (about 85 percent of all HHAs) had an aggregate margin of 14.4 percent. HHAs that served mostly urban patients in 2012 had an aggregate margin of 14.8 percent; HHAs that served mostly rural patients had an aggregate margin of 12.8 percent. The 2012 margin is consistent with the historically high margins the home health industry has experienced under the prospective payment system. The margin from 2001 to 2012 averaged 17.5 percent, indicating that most agencies have been paid well in excess of their costs under the prospective payment system.

- For-profit agencies in 2012 had an average margin of 15.2 percent, and nonprofit agencies had an average margin of 12.0 percent.

- Agencies that serve more patients have higher margins. The agencies in the lowest volume quintile in 2012 have an aggregate margin of 6.8 percent, while those in the highest quintile have an aggregate margin of 16.7 percent.

Chart 8-12. Most common types of inpatient rehabilitation facility cases, 2013

Type of case	Share of cases
Stroke	19.4%
Fracture of the lower extremity	12.6
Neurological disorders	12.5
Debility	10.3
Major joint replacement	8.8
Brain injury	8.1
Other orthopedic	7.6
Cardiac conditions	5.4
Spinal cord injury	4.5
Other	10.7

Note: "Other" includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS (January through June of 2013).

- In 2013, the most frequent diagnosis for Medicare patients in inpatient rehabilitation facilities (IRFs) was stroke, representing close to 20 percent of cases.
- Major joint replacement cases represented 8.8 percent of IRF admissions in 2013, down from 24 percent in 2004, when major joint replacement was the most common IRF Medicare case type.
- The share of cases represented by patients with neurological disorders has been steadily increasing since 2004, while the share of major joint replacement cases has been steadily decreasing. In 2012, the share of neurological disorders exceeded the share of major joint replacement for the first time.

Chart 8-13. Number of IRF FFS patients increased in 2012

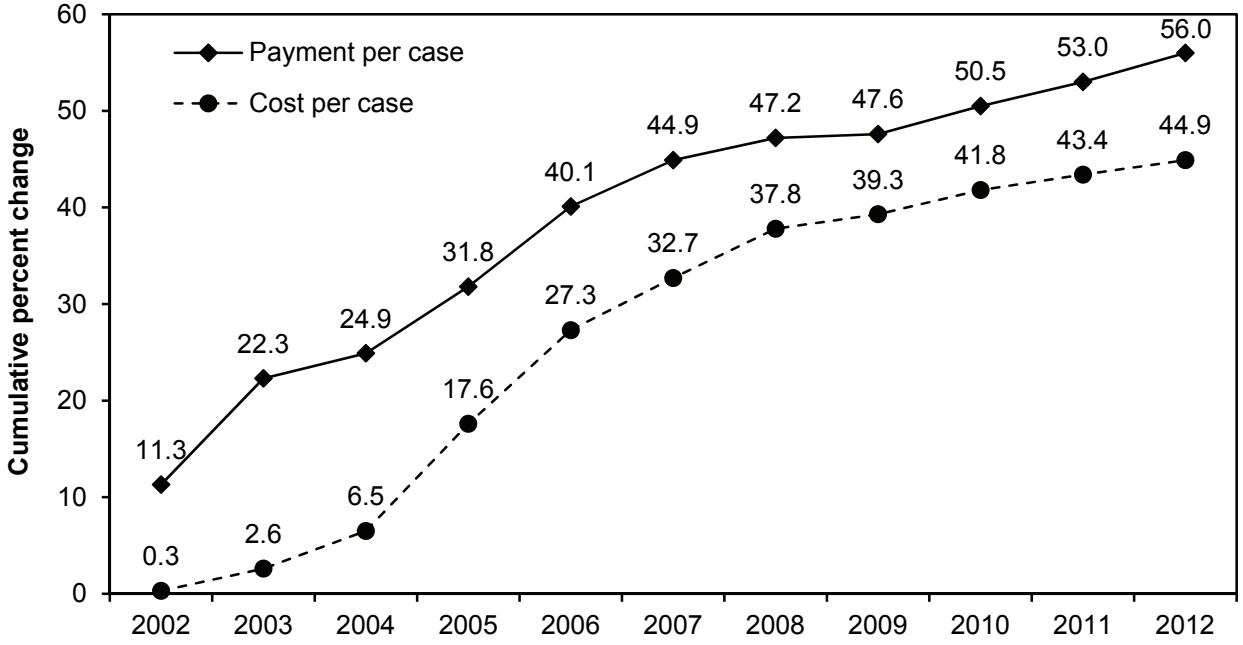
	2004	2010	2011	2012	Average annual percent change 2004–2011	Percent change 2011–2012
Number of IRF cases	495,000	359,000	371,000	373,000	–4.0%	0.5%
Unique patients per 10,000 FFS beneficiaries	124.4	91.2	93.1	92.4	–4.0	–0.8
Payment per case	$13,290	$17,085	$17,398	$17,995	4.0	3.4
Average length of stay (in days)	12.7	13.1	13.0	12.9	0.4	–0.8

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Numbers of cases reflect Medicare FFS utilization only.

Source: MedPAC analysis of MedPAR data from CMS.

- IRF volume is measured by the number of IRF cases and the number of unique patients per 10,000 beneficiaries, which controls for changes in FFS enrollment.
- IRF volume declined from 2004 through 2008, when enforcement of the compliance threshold was renewed. After 2008, the volume decline began to level off after the compliance threshold was permanently lowered to 60 percent.
- Between 2011 and 2012, the number of cases grew by 0.5 percent. This growth continues an upward trend in the number of IRF cases since 2010.
- While Medicare FFS spending on IRFs declined from 2004 through 2008, total Medicare spending rose 4.0 percent from 2011 to 2012.

Chart 8-14. Overall IRF payments per case have risen faster than costs since implementation of the PPS in 2002



Note: IRF (inpatient rehabilitation facility), PPS (prospective payment system). Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of cost report data from CMS.

- Since implementation of the PPS in 2002, overall Medicare payments per case have cumulatively increased more than costs per case. In most years from 2004 through 2009, costs per case grew more than payments, although payments per case have grown more than costs each year since 2010.
- Between 2011 and 2012, payments per case increased more than costs per case.
- These trends in Medicare per case payments and costs are reflected in IRFs' Medicare margins, shown in Chart 8-15.

Chart 8-15. Inpatient rehabilitation facilities' Medicare margin by type, 2002–2012

	2002	2004	2006	2008	2010	2011	2012
All IRFs	10.8%	16.7%	12.4%	9.3%	8.7%	9.8%	11.1%
Hospital based	6.1	12.2	9.6	3.8	–0.4	–0.1	0.8
Freestanding	18.5	24.7	17.5	18.1	21.3	22.9	23.8
Urban	11.3	17.0	12.6	9.5	9.0	10.2	11.4
Rural	5.9	13.9	10.6	7.2	5.6	6.1	7.3
Nonprofit	6.5	12.8	10.7	5.3	2.1	2.0	2.1
For profit	18.5	24.4	16.3	16.8	19.6	21.0	22.9

Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of cost report data from CMS.

- Freestanding and for-profit IRFs had substantially higher aggregate Medicare margins than hospital-based and nonprofit IRFs, continuing a trend that began with implementation of the IRF prospective payment system (PPS) in 2002.
- Medicare margins increased rapidly during the first two years (2002–2004) of the IRF PPS across all provider types. Aggregate margins rose from just under 2 percent in 2001 to almost 17 percent in 2004.
- Margins declined each year from 2004 (16.7 percent) to 2009 (8.4 percent). This decline was largely due to reductions in patient volume through 2008, resulting in fewer patients across whom to distribute fixed costs. Since 2010, aggregate margins have increased each year.
- Between 2011 and 2012, Medicare margins increased from 9.8 percent to 11.1 percent (an increase of 13 percent).

Chart 8-16. The top 25 MS–LTC–DRGs made up nearly two-thirds of LTCH discharges in 2012

MS–LTC–DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	15,842	11.3%
189	Pulmonary edema and respiratory failure	14,036	10.0
871	Septicemia without MV 96+ hours with MCC	8,954	6.4
177	Respiratory infections and inflammations with MCC	4,546	3.2
592	Skin ulcers with MCC	4,004	2.8
208	Respiratory system diagnosis with ventilator support < 96 hours	3,060	2.2
949	Aftercare with CC/MCC	3,060	2.2
539	Osteomyelitis with MCC	2,605	1.9
190	Chronic obstructive pulmonary disease with MCC	2,466	1.8
193	Simple pneumonia and pleurisy with MCC	2,259	1.6
919	Complications of treatment with MCC	2,200	1.6
559	Aftercare, musculoskeletal system and connective tissue with MCC	2,190	1.6
682	Renal failure with MCC	2,142	1.5
314	Other circulatory system diagnoses with MCC	2,061	1.5
862	Postoperative and post-traumatic infections with MCC	2,053	1.5
570	Skin debridement with MCC	1,965	1.4
870	Septicemia with MV 96+ hours	1,928	1.4
166	Other respiratory system OR procedures with MCC	1,899	1.4
4	Tracheostomy with MV 96+ hours or primary diagnosis except face, mouth & neck without major OR	1,840	1.3
291	Heart failure and shock with MCC	1,749	1.2
853	Infectious and parasitic diseases with OR procedure with MCC	1,561	1.1
602	Cellulitis with MCC	1,523	1.1
603	Cellulitis without MCC	1,487	1.1
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,455	1.0
371	Major gastrointestinal disorders & peritoneal infections with MCC	1,424	1.0
	Top 25 MS–LTC–DRGs	88,309	62.9
	Total	140,496	100.0

Note: MS–LTC–DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), MV (mechanical ventilation), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS–LTC–DRGs are the case-mix system for LTCHs. Columns may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2012, the top 25 MS–LTC–DRGs accounted for more than 60 percent of all cases.

- The most frequent diagnosis in LTCHs in 2012 was respiratory system diagnosis with ventilator support for more than 96 hours. Nine of the top 25 diagnoses, representing 42 percent of all cases, were respiratory conditions or involved prolonged mechanical ventilation.

Chart 8-17. The number of Medicare LTCH cases and users holding steady

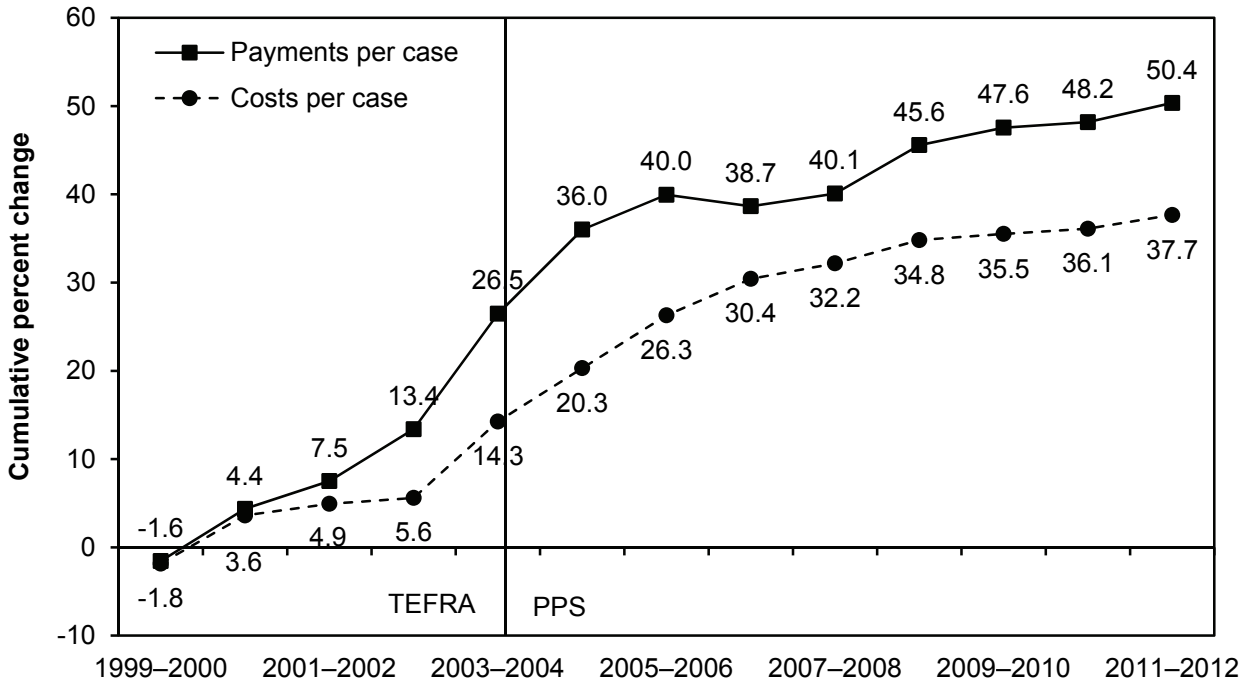
						Average annual change			
	2004	2005	2007	2011	2012	2004–2005	2005–2007	2007–2011	2011–2012
Cases	121,955	134,003	129,202	139,715	140,463	9.9%	–1.8%	2.0%	0.5%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.2	38.3	37.9	9.0	–0.3	1.4	–1.0
Spending per FFS beneficiary	$ 101.3	$ 122.2	$ 126.0	$ 148.0	$149.6	20.7	1.5	4.1	1.1
Payment per case	30,059	33,658	34,769	38,664	39,493	12.0	1.6	2.7	2.1
Length of stay (in days)	28.5	28.2	26.9	26.3	26.2	–1.1	–2.3	–0.5	–0.4
Users	108,814	119,282	114,299	122,838	123,652	9.6	–2.1	1.8	0.7

Note: LTCH (long-term care hospitals), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

- Between 2011 and 2012, the number of beneficiaries who had LTCH stays (users) increased by 0.7 percent.
- Controlling for the number of FFS beneficiaries, the number of LTCH cases declined 1.0 percent between 2011 and 2012. The decline is due at least in part to a congressional moratorium that limited growth in the number of LTCHs.

Chart 8-18. LTCHs' per case payments continue to increase more than costs



Note: LTCH (long-term care hospital), TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), PPS (prospective payment system). Percent changes are calculated based on consistent two-year cohorts of LTCHs.

Source: MedPAC analysis of Medicare cost report data from CMS.

- In the first years of the PPS, costs per case increased rapidly, following a surge in payments per case.
- Between 2005 and 2007, growth in cost per case slowed considerably, as regulatory changes to Medicare's payment policies for LTCHs slowed growth in payment per case.
- Since 2007, LTCHs have held cost growth below the rate of market basket increases. Between 2009 and 2011, the average cost per case increased less than 1.0 percent per year. Between 2011 and 2012, the average cost per case increased 1.6 percent.

Chart 8-19. The aggregate LTCH Medicare margin rose in 2012

Type of LTCH	Share of discharges	2004	2006	2008	2010	2011	2012
All	100%	9.0%	9.7%	3.6%	6.7%	6.7%	7.1%
Urban	95	9.2	9.9	3.9	7.0	6.8	7.2
Rural	4	2.6	4.7	–3.2	–0.1	3.0	3.4
Nonprofit	14	6.9	6.5	–2.5	–0.2	0.9	–1.4
For profit	84	10.0	10.9	5.3	8.2	8.2	8.9
Government	2	N/A	N/A	N/A	N/A	N/A	N/A

Note: LTCH (long-term care hospital), N/A (not available). "Share of discharges" column groupings may not sum to 100 percent due to rounding or missing data. Margins for government-owned providers are not shown. They operate in a different context from other providers, so their margins are not necessarily comparable.

Source: MedPAC analysis of cost report data from CMS.

- After implementation of the prospective payment system, LTCHs' Medicare margins increased rapidly for all LTCH provider types, climbing to 11.9 percent in 2005 (data not shown). Margins then fell as growth in payments per case leveled off.
- In 2009, LTCH margins began to climb again as providers consistently held cost growth below that of payments. In 2012, the aggregate margin was 7.1 percent.
- Financial performance in 2012 varied across LTCHs. The aggregate Medicare margin for for-profit LTCHs (which accounted for 84 percent of all Medicare discharges from LTCHs) was 8.9 percent. Rural LTCHs' aggregate margin was 3.4 percent, compared with 7.2 percent for their urban counterparts. Rural providers account for about 4 percent of LTCH discharges and care for a smaller volume of patients on average, which may result in fewer economies of scale.